Approval:
Arlene Crosby
(Manager and/or President)
Date: 10/12/01

RESPONSE TO REQUEST FOR FAMILY MEDICAL LEAVE

DATE: 10/12/01

TO: Laura Patrick
(Employee's Name)
Social Security Number: 025-52-1357
Address: 5 Emerald Ave
City, State: Marblehead MA
Zip: 01945
Phone Number: 781-639-0902
Department: Design

FROM: Janssen
(Company Name, Location)
Kathleen Greene
(Employer Representative)

SUBJECT: FAMILY / MEDICAL LEAVE

EXHIBIT
Patrick 6
SUP 1/25/05

- ☒ New Leave of Absence
- ☐ Extension of Previous Leave
- ☐ Revision of Previous Leave

I. On 8/15/01 (date), you notified us of your need to take family/medical leave due to:

(a) ☐ The birth of your child, or the placement of a child with you for adoption or foster care. The date of birth or placement of a child for adoption or foster care is anticipated to occur on _____ (date); or

(b) ☒ A serious health condition that makes you unable to perform the essential functions of your job; or

(c) ☐ A serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care.

(d) ☐ A serious health condition resulting from a Workers' Compensation qualifying injury.

II. You notified us that:

(a) ☒ You project this leave to begin on 10/15/01 (start date) and that you expect the leave to continue until on or about 11/26/01 (end date) and returning to work the following day for a total of 6 weeks after the actual commencement date.

(b) ☐ This leave is for recurring medical treatments
- ☐ on dates identified on the attached schedule; or
- ☐ to be determined.

(c) ☐ This leave is for intermittent leave with dates:
- ☐ identified on the attached schedule; or
- ☐ to be determined.

III. 12/12/01 is scheduled to be / was your last day of work.
(date of *last day of work*)

IV. You understand and agree to the following:

(a) If you are eligible for a family / medical leave of absence under the Family Medical Leave Act (FMLA) you have a right to take up to a total of 12 weeks of leave in a 12-month period for the reasons listed above.

(b) Your current Health and Dental benefits will be maintained by the company during any period of unpaid leave under the same conditions as if you continued to work provided that you comply with health and dental benefit payment procedures as explained below.

(c) You will be reinstated to the same or an equivalent job and status with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than:
(1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or
(2) other circumstances beyond your control,
you will be required to reimburse the company for its share of the costs of health and dental coverage paid on your behalf during your FMLA leave.

(d) When your leave is over, you will return to work at the same status as when you began the leave unless your supervisor has given written approval of a requested status change prior to your return from leave.

(e) The duration of this leave and all other leaves during this year (12-month period running January – December) will not exceed a total of 12 weeks.

V. This is to inform you that:

(a) If your leave is needed due to a Serious Health Condition, you **WILL** be required to furnish certification by a health care provider of the Serious Health Condition by _____ (date) *(must be at least 15 days after you are notified of this requirement)* or we may delay the commencement of your leave until certification is received.

(b) The requested leave will be counted against your annual FMLA leave entitlement of a total of 12 weeks

(c) It is required that you use accrued paid leave for unpaid FMLA leave as set out below

(d) Paid Benefits Taken During Leave must be designated by type as Vacation (V), Personal Leave (P), and Sick (S):

Total Paid Benefits Available (in weeks) V ___ P ___ S ___

	Payroll End	# of Hours / Type		Payroll End	# of Hours / Type
Week 1			Week 7		
Week 2			Week 8		
Week 3			Week 9		
Week 4			Week 10		
Week 5			Week 11		
Week 6			Week 12		

(e) Additional benefits will not accrue during any leave lasting longer than 4 work weeks after any paid time off. However, you will not lose benefit credits attained prior to the commencement of your leave.

(f) You presently have ☒ SINGLE ☐ SINGLE + 1 ☐ FAMILY ☐ NO health coverage and

☐ SINGLE ☐ SINGLE + 1 ☒ FAMILY ☐ NO dental coverage. Arrangements for payment have been discussed with you and you agree that you will make premium payments within one (1) pay period of commencement of leave of absence. You will receive an initial schedule of premiums due and you will receive billing from that point forward.

(g) You must pay your portion of the cost for health and dental coverage for each pay period you are on leave. You may also elect to prepay your health and dental premiums before beginning your FMLA qualified leave.

☐ PREPAY PREMIUMS
☐ HEALTH PREMIUM $_____
☐ DENTAL PREMIUM $_____

SC 12/14

(h) You have a 30-day grace period in which to make payments for group health and dental benefits. If payment is not made timely, your group health and dental coverage will be canceled, provided we notify you in writing at least 15 days before the date your health and dental coverage will lapse.

(i) You ☒ WILL ☐ WILL NOT be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required your return to work will be contingent upon receipt of such certification and your reinstatement may be delayed until the certification is provided.

(j) While on leave, you ☒ WILL ☐ WILL NOT be required to furnish us with periodic reports every 30 Days (*indicate interval of periodic reports, as appropriate for the particular leave situation*) of your status and intent to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated previously on this form, you ☐ WILL ☒ WILL NOT be required to notify us at least two (2) work days prior to the date you intend to report to work and obtain management approval to return early.

(k) You will be required to furnish additional medical certification reports relating to a Serious Health Condition every 30 days.

1 copy to employee / 1 copy to Taylor Corporation payroll / 1 copy to personnel file

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

1. Employee's Name: Laura Petrick

2. Patient's Name (if different from employee):

3. The definition of a "**serious health condition**" under the Family and Medical Leave Act is set forth on the back of this form. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category. (See reverse for explanation)

(1)___ (2)✓ (3)___ (4)___ (5)___ (6)___, or None of the above _____

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:
Patient will need to be available for daily blood work and ultrasounds and will need to have 2 office visits for procedures.

5.a. State the approximate **date** the condition commenced, and the probable **duration** of the condition (and also the probable duration of the patient's present **incapacity**[2] if different):
Patient will be unable to work from Oct 15, 2001 - Nov. 26, 2001

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)? _____

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]:

6.a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments:

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c. If a **regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

---

[1] Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

[2] "**Incapacity**," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

1 copy to employee / 1 copy to Taylor Corporation payroll / original to personnel file

7.a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? _____ If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

8.a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?_____

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?_____

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

(Signature of Health Care Provider) (Type of Practice)

(Address) (Telephone number) (Date)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

(Employee signature) (Date)

(Print Name)